

Promising Practices Case Study:
Integration, Language and Cultural Interpretation – A 3-Staged Interpretation Model
(Centre for Addiction and Mental Health, Toronto)

The Issue

In the world of language interpretation, the distinctions between cultural interpreting and language interpreting have sparked considerable debate about which approach is most effective for delivering quality services to newcomers.

Language interpretation is bidirectional interpreting that takes place in the course of communication among speakers of different languages. The role of the interpreter is to facilitate verbal communication by conveying as faithfully as possible a message between two parties who do not share a common language. Further, the interpreter must be able to understand and convey cultural nuances without assuming the role of advocate or cultural broker.¹ Proponents of language interpretation hold that adding the 'cultural brokerage' function to this role not only burdens the interpreter with responsibilities outside their scope, but also gives rise to conflict of interest. They argue that expecting an interpreter to perform this function, in and of itself, is in contravention of the ethical principle and standard of practice to remain impartial, and furthermore begs the question of the interpreter's competency to perform this function.

Proponents of language interpretation view culture as a rich, nuanced and non-generalizable entity that an interpreter may not be able to fully comprehend, let alone dissect. They argue that cultural differences can exist between individuals who do share a common language. Given the complexity of factors that impact and influence an individual's culture, acting as a "cultural broker/bridge" goes beyond the scope of an interpreter's duty.

Central to their objection is the notion that "cultural brokers" can, in speaking for the client, minimize the client's voice. They argue that clients must speak for themselves. The role of the interpreter should be to focus on the delivery of messages between individuals who do not share a common language rather than "cultural differences/nuance" of the speakers.

On the other hand, proponents of the cultural interpreter approach argue that a cultural interpreter is an advocate or "cultural broker". The interpreter acts in collaboration with the service provider in generating the cultural formulation and recommendation. In this context, the interpreter should speak the specific dialect of the patient and be well versed with local knowledge, cultural beliefs, and practices of the patient's cultural group. The interpreter should be aware of his/her own values, biases and emotional reactions to patients' material and be comfortable with cultural differences in relationships.² They argue that cultural interpretation is indispensable because culture is undeniably important. Culture leads to nuanced and complex understandings of the issue at hand. While it is not

¹ Healthcare Interpretation Network. (2007). *National Standard Guide for Community Interpretation Services*. Retrieved 02 21, 2010, from: <http://healthcareinterpretation.homestead.com/standards.html>

² <http://www.mcgill.ca/culturalconsultation/handbook/culture-broker/>

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generalizable, there are things which are general enough and training is available to help guide an interpreter through this terrain.

The Model

CAMH named their interpretation services *Cultural Interpretation Services(CIS)* because they recognize that culture is undeniably present when providing interpretation for clients receiving mental health services. "For mental health clients, everything is in the mind. A lot of what they speak is cultural and we need to understand this for service delivery," says Rahman, Clinical Services Consultant at CAMH. Yet, they also recognize that language (faithful) interpretation has an important place.

CIS has created an innovative model that aims to breach the gap between language interpretation and cultural interpretation using a 3-staged approach to interpretation. It should be mentioned here that CIS does not follow the 3-staged process with every assignment. Sessions are assessed on a case by case basis and the 3-staged approach is arranged when required.

Stage 1: The preamble. The clinician and the interpreter meet prior to the interpretation session to discuss the client's case and needs. They discuss their respective roles and duties, to clarify the goals of the interview, and to address any special considerations related to mental health issues. Here, the clinician may ask questions about the client's culture as cultural competency is expected of the clinician.

Stage 2: Interpretation. The clinician, the interpreter and the client meet and the interpreter conducts faithful (verbatim) interpretation of everything that is said between the client and the clinician. Both the clinician and the interpreter may take mental note of emotional reactions, cultural nuances, etc, but they don't speak of it during the interpretation session.

Stage 3: Debriefing. The clinician and the interpreter meet after the client has left to discuss observations and points that need clarification or another clinical session. Here, the clinician and the interpreter can discuss cultural issues/observations. While the interpreter plays the cultural broker role, the clinician is expected to be culturally competent and to initiate queries.

Strengths

This model overcomes many of the concerns raised by proponents of both language and cultural interpretation. First, the actual interpretation session is bidirectional and conducted faithfully (verbatim). At the same time, the emphasis on culture isn't lost since both the interpreter and the clinician discuss 'cultural' issues in the debriefing session. Second, cultural brokering and advocacy are responsibilities shared by both interpreter and clinician since clinicians are also expected to be culturally competent. Third, separating language interpretation (Stage II) and cultural brokering (Stage III) mitigates conflict of interest concerns as interpreters carry out their interpreting duties faithfully and impartially in the interpretation session. Fourth, uncertainty about the cultural interpreter's competence to perform this function are reduced because cultural interpreters are not only well versed with local knowledge, cultural beliefs, and practices of the patient's cultural group, but also trained to be aware of his/her own values, biases and emotional reactions to patients' material and be comfortable with cultural differences in relationships.

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Weaknesses

The model has several limitations. First, the client does not attend the debriefing session, and therefore can be perceived as lacking 'agency' or 'voice'. This dilemma could be overcome by making a list of issues and posing them to the client directly at a follow-up session. Second, there needs to be acknowledgement, not only among interpreters, but also among service providers, that cultural differences exist among people who speak the same language, and that additional efforts need to be in place to mitigate possible misunderstandings and deliver culturally competent services. Third, although service providers share some cultural brokering and advocacy responsibility, this model expects significantly larger involvement from interpreters. Finally, this model requires significant funding to administer and for interpreter and staff time. It may not be sustainable for organizations that do not have access to ongoing funding.

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